Evaluation plays a key role in developing and sustaining community partnerships and coalitions. We recommend focusing on three levels of coalition evaluation that measure (a) processes that sustain and renew coalition infrastructure and function; (b) programs intended to meet target activities, or those that work directly toward the partnership’s goals; and (c) changes in health status or the community. A tendency to focus on quick wins and short-term effects of programs may explain why some coalitions are not able to achieve systems and/or health outcomes change. Although measuring community-level or system changes (e.g., improving environmental quality or changing insurance coverage policies) is much more difficult than evaluating program outcomes, it is essential. This article presents challenges that coalition practitioners and evaluators face and concludes with practical resources for evaluation.

Keywords: coalitions; partnerships; evaluation; outcomes; capacity building

Today, communities, organizations, businesses, and nations often develop alliances, joint ventures, and public-private partnerships. One type of strategic relationship, a coalition, forms when different sectors of the community, state, or nation join together to create opportunities to benefit all partners. Community coalitions have the potential to involve multiple sectors of the community and to conduct multiple interventions that focus on individuals and their environments. The pooling of resources and the mobilization of talents and diverse approaches inherent in a successful coalition approach make it a logical strategy for disease prevention based on a social ecological model that acknowledges the significance of the environment on health (McLeroy, Bibeau, Steckler, & Glanz, 1988).

Government and private-sector funding agencies have begun to require coalition formation as an essential part of the programs they support (Cheadle et al., 1997). The W. K. Kellogg Foundation’s Community-Based Public Health Initiative (1994), the Robert Wood Johnson Foundation “Fighting Back” substance abuse prevention and Allies Against Asthma initiatives, the Office of Minority Health’s REACH initiative and the Centers for Disease Control and Prevention’s (CDC) obesity prevention programs are but a few examples. These and other public health efforts assume that programs designed, implemented, and owned by community coalitions will be far more effective than those developed by a single public or private group.

Unfortunately, not every coalition has been successful, and not every coalition has achieved its results without having paid a high price for its success (Dowling, O’Donnell, & Wellington Consulting Group, 2000; Wolff, 2001). Although coalitions are usually built from unselfish motives to improve communities, they still may experience difficulties that are common to many types of organizations, as well as some that are unique to collaborative efforts. When a coalition is started, frustrations may arise. Promised resources may not be made available; conflicting interests may prevent the coalition from having its desired effect in the community; and recognition for accomplishments may be slow in coming. Because coalition building involves a long-term investment of time and resources, a coalition should not be established if a simpler, less complex structure will get the job done or if the community does not embrace this approach. Practical, field-based evidence is needed to document how coalitions function and sustain themselves, and whether they actually have an impact on the public’s health.
WHY PARTNERSHIPS AND COALITIONS?

Community partnerships and coalitions form when grassroots groups seek power in numbers, when new funding opportunities arise or when budget cuts demand consolidation or collaboration. A classic definition of community coalitions describes them as organizations of “diverse interest groups that combine their human and material resources to effect a specific change; the members are unable to bring about independently” (Brown, 1984, p. 4). Coalitions and similar partnerships distinguish themselves by being collaborative and synergistic working alliances. Coalitions serve several critical purposes (Black, 1983; Brown, 1984; Feighery & Rogers, 1989; Klitzner, 1991; Roberts-DeGennaro, 1986), including (a) enabling organizations to become involved in new and broader issues without having the sole responsibility for managing or developing those issues; (b) mobilizing talents, resources, and approaches to develop widespread public support for issues, actions, or unmet needs; (c) increasing the critical mass behind a community effort by helping individuals achieve objectives beyond the scope of any one individual or organization; and (d) minimizing duplication of effort and services by improving trust and communication among previously competing groups.

Organizations engage in coalition work for many reasons, including increased networking, information sharing, and access to resources; being involved in an important cause and achieving desired outcomes; and receiving recognition (Butterfoss, Goodman, & Wandersman, 1993). Similarly, organizations experience costs by participating in coalitions, such as significant time commitments, lost autonomy in decision making, lack of direction from coalition leadership or staff, perception of lack of recognition or appreciation, burnout, lack of necessary skills, and pressure for additional commitment (Wandersman & Alderman, 1993). To maintain active member participation, the benefits of participating in coalitions must outweigh the costs. A coalition usually focuses on preventing or ameliorating a community problem by (a) analyzing the problem; (b) gathering data and assessing need; (c) developing an action plan with identified solutions; (d) implementing those solutions; (e) reaching community-level outcomes, such as health behavior changes; and (f) creating social change (Whitt, 1993).

Furthermore, conditions for successful coalition implementation and attainment of valued outcomes—especially changes in behavior(s) and in more distal outcomes—include several factors. These factors include having (a) a shared and focused mission, (b) a strategic plan that specifies what features of the physical and social environment need to change to reach the intended outcomes, (c) charismatic and distributed leadership, (d) paid staff and community mobilizers, (e) a documentation and feedback system that is based on a solid evaluation plan, (f) technical assistance that is coupled with evaluation, and (g) making the outcomes matter (Fawcett, Francisco, Paine-Andrews, & Schultz, 2000).

EVALUATING COALITIONS

Evaluation plays a key role in developing and sustaining a community coalition. Evaluation can serve many purposes and answer key questions, such as to:

- provide accountability to the community, stakeholders, and funding agencies (Are members satisfied and making a contribution? Did the coalition use resources wisely?)
- determine whether objectives are met (Did the program achieve its goals?)
- improve program implementation or develop better approaches (Were programs effective?)
- increase community awareness and support (Is the community aware of coalition efforts? Are they behind the coalition effort?)
- inform policy decisions (Did elected officials support legislation proposed by the coalition?)
- contribute to the scientific base of understanding what works (Does a coalition approach work?).

USING THEORIES AND LOGIC MODELS AS A FRAMEWORK FOR EVALUATION

Certain theoretical assumptions form the framework on which most community coalitions are, or should be, built. A number of practice-proven propositions have arisen about developing and maintaining coalitions, as well as how they result in successful actions and health outcomes. These propositions form the basis for the recently developed Community Coalition Action Theory that may be used to develop the basics of your coalition evaluation plan (Butterfoss & Kegler, 2002). Other practical frameworks and models that can lead to choosing effective coalition evaluation methods and measures include the Centers for Substance Abuse, Getting to Outcomes (Chinnman et al., 2001), the KU Work Group’s framework for community coalition evaluation.
(Fawcett et al., 1995; Francisco, Fawcett, Schultz, & Paine-Andrews, 2000) and the CDC’s Framework Featuring Steps and Standards for Program Evaluation (Millstein, Wetterhall, & CDC, 2000). In addition, many large-scale coalition efforts develop their own logic models and evaluation plans that can be readily obtained.

LEVELS OF COALITION EVALUATION

A coalition should evaluate at three levels to measure (a) processes that sustain and renew coalition infrastructure and function; (b) programs intended to meet target activities, or those that work directly toward the partnership’s goals; and (c) changes in health status or the community.

Level 1: Coalition Infrastructure, Function, and Processes

In the early stages, coalitions create mission statements, set up work groups, conduct needs assessments, and develop action plans. To sustain momentum, a coalition has to recruit and orient new members, train leaders, prepare leaders-in-waiting to take over when there is turnover, address and resolve conflict, engage in public relations, celebrate its accomplishments, and raise funds. A process evaluation documents what was done, how many people were reached by coalition efforts, and whether the coalition itself is functioning optimally or as originally intended. Good record keeping is essential. Collecting and analyzing annual reports, attendance records, contribution records, meeting minutes, activity logs, and surveys that measure members’ levels of satisfaction, commitment, and participation are methods and measures that may be used to document coalition structure and function.

Level 2: Coalition Programs and Interventions

If a coalition is to survive, it must produce more than a sense of solidarity among members; it must engage in the tasks and produce the products for which it was created. In the implementation phase, the actual coalition activities (e.g., training, advocacy, education programs) are carried out. For example, a community partnership to prevent obesity might develop after-school activities, parent training, public awareness campaigns, or advocate for changes in school lunch policies. Successful implementation depends on available resources, a time-phased action plan and a supportive environment. The likelihood of achieving program outcomes depends on the extent to which strategies are implemented and reach the priority populations. Adaptations of interventions that have been previously evaluated or accepted as promising practices increase the likelihood that interventions will result in community change and, ultimately, desired health and social outcomes. Evaluation of whether specific objectives concerning programs have been met, partly met, or not met will help planners assess coalition progress. Surveys and interviews, focus groups, observations of clinic functioning, emergency department and hospital records, patient records, home visit logs and diaries, media reach reports, and event participation logs are methods and measures that can help determine if programs are being implemented with fidelity and success.

Level 3: Health and Community Change Outcomes

What has the coalition accomplished? For many, including coalition members and funders, this is the bottom line. This phase of evaluation concerns itself with actions that have achieved the coalition’s goals and objectives. Epidemiologi-
cal data will inform coalitions as to whether the prevalence of overweight and obesity was reduced. Patient records can be reviewed to determine whether medical personnel adopted practice guidelines. Legislative records can show whether proposed policies were introduced and/or passed. Key informants can assess whether school policies and curricula have changed as a result of coalition efforts or whether coalition programs have been institutionalized within their organizations.

THE ISSUE OF SHORT-TERM VERSUS LONG-TERM CHANGES

Evaluators must concern themselves with short-term or direct effects of the program, as well as with the long-term, ultimate effects desired by a community-organizing effort or program. In asthma management programs, such as Allies Against Asthma, effects include reduction in emergency room visits and hospitalizations.

Coalitions must accomplish “quick wins” and short-term successes to increase member commitment and to build the credibility of the coalition before it can focus on more complex programs (Brown, 1984; Cohen, Baer, & Satterwhite, 1991; Croan & Lees, 1979; Hord, 1986). However, if coalitions are to help improve the health status of the community, they have to evaluate the impact they have on improving the social and health systems and outcomes of the community (Sink & Stowers, 1989). A tendency to focus on quick wins may help to maintain member interest but is unlikely to lead to significant outcomes and may explain why some coalition programs are not able to achieve systems and/or health outcomes change (Kreuter, Lezin, & Young, 2000). Measuring community-level or system changes (e.g., improving environmental quality or changing insurance coverage policies) is much more difficult than evaluating program outcomes (Kagan, 1991).

CHALLENGES FOR COALITION PRACTITIONERS AND EVALUATORS

Coalition evaluation is fraught with barriers. Because funds are more likely to be spent on intervention, evaluation is often not built into the planning process and is not funded or inadequately funded. Because it can be costly in terms of time and resources, evaluation does not always have the commitment of the lead agency, staff, and members. If it is supported, coalition coordinators and program managers are motivated to make programs ‘look’ effective to maintain funding or their jobs. Evaluation may not be based on a solid logic model or theory and often ends up being a do-it-yourself evaluation.

The complex issues that many coalitions address take concerted and long-range efforts. Distinguishing between cause and effect or what percentage of the outcome can be attributed to which coalition program or activity is often difficult. As interventions become more complex and focus less on individual behavior change, the coalition needs to focus across multiple levels and take community readiness into account (Goodman et al., 1998). Successful activities and programs probably need to be repeated. This requires institutionalizing the program or community-organizing effort either in the coalition or in one of its member organizations. In addition, institutionalization of the coalition itself (or its functions) should be a long-range goal and a milestone of coalition success.

Besides design issues and secular trends that make detecting community-level change challenging, coalitions tend to focus on quick wins and awareness activities that do not, in of themselves, lead to significant changes in systems or health status (Berkowitz, 2001; Kreuter et al., 2000; Mittelmark, 1999; Roussos & Fawcett, 2000). Most of the published coalition evaluation research consists of single or multiple case studies that do not support strong conclusions about the impact of partnerships on population-level outcomes, such as changes in health status (Fawcett et al., 1997; Kegler, Steckler, Malek, & McLeroy, 1998; Kreuter et al., 2000; Morrow et al., 1998; Roussos & Fawcett, 2000).

Although partnerships have helped change community-wide behavior, the strongest evidence shows that coalitions contribute to changes in programs, services, and practices (Roussos & Fawcett, 2000).

In addition to coalition outcomes associated with health or social issues, another set of outcomes is associated with increases in a community’s capacity to solve problems (Goodman et al., 1998). Coalitions can affect a community’s capacity by positively or negatively affecting participation, leadership, networks of individuals and organizations, skills, resources, and sense of community. Current evaluation research has begun to focus on outcomes associated with community capacity and these issues.

PRACTICAL RESOURCES FOR PARTNERSHIP AND COALITION EVALUATION

Numerous resources are at your fingertips to make evaluation of
Published Manuals:


WEB SITES AND OTHER RESOURCES:

The Community Toolbox: http://cth.ku.edu/

The Partnership Self-Assessment Tool: www.partnershiptool.net


Self-help software for survey development:
- SurveyKey: www.surveykey.com/
- Survey Suite: http://intercom.virginia.edu/cgi-bin/cgiwrap/intercom/SurveySuite/SSS_index.pl
- Formsite: www.formsite.com
- Zoomerang: www.zoomerang.com

CDC: EZ-TEXT free Windows software program to help create, manage, and analyze semistructured qualitative databases and AnSWER analysis software for integrating quantitative and qualitative evaluation techniques.
- www.cdc.gov/nchstp/hiv_aids/software/ez-text.htm
- www.cdc.gov/nchstp/hiv_aids/software/answr.htm
- INNONET Evaluation Toolbox: www.innonet.org

PROMES2 software for project management, monitoring and evaluation. E-mail: mdf@mdf.nld.toolnet.org


Online guide for program evaluation: www.mapnp.org/library/evaluatin/fni_eval.htm

Guide to capacity inventories: Mobilizing the Community Skills of Local Residents (Kretzmann, McKnight, & Sheehan): www.nwu.edu/PR/publications/capinv.html

Mapping community capacity (McKnight & Kretzmann): www.
CONCLUSION

Community coalitions and partnerships can be powerful agents for social change and for solving complex public health challenges. Coalitions may be seen as a panacea, as one tool for accomplishing complex tasks, or as a way to build community capacity and self-determination. However, coalitions can also be time-consuming and difficult, especially when resources are limited (Cheadle et al., 1997). Conference report: Community-based health promotion—State of the art and recommendations for the future. American Journal of Preventive Medicine, 13(4), 240-243.


REFERENCES


